JOHNS HOPKINS
UNIVERSITY & MEDICINE

JHHS & JHU VACCINE MEDICAL EXCEPTION FORM
REQUEST FOR MEDICAL EXCEPTION FROM FLU VACCINATION

PLEASE PRINT THE FOLLOWING INFORMATION (JOHNS HOPKINS AFFILIATE):

Name:____ Date of Birth: ______________________________________

E-mail:____ Phone/Pager No.: __________________________________

Department/School:_____________________________ Supervisor/Manager: _______________________________

Dear Health Care Provider (MD, NP, DO, PA):

Johns Hopkins Health System and Johns Hopkins University requires influenza vaccination similar to other required vaccinations such as MMR and varicella. For decades influenza vaccination has been recommended for healthcare workers because they have been shown to be effective in reducing the incidence of influenza in inpatient populations. Influenza vaccination has also been recommended in pregnancy by the Centers for Disease Control to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born. The above named person is requesting an exception from this vaccination requirement. A medical exception from influenza vaccination is allowed for certain recognized contraindications (CDC MMWR Early Release 2011; Vol. 60).

Please complete the form below. Should you have any questions, please contact the appropriate office listed below.

The above-named person should not be immunized for flu for the following reasons (please check all that apply):

☐ History of previous allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine. **Please attach supporting DOCUMENTATION or MEDICAL RECORDS.**
☐ History of Guilain-Barre Syndrome within six weeks of receiving a previous vaccine. Please provide and attach a detailed narrative that describes the event.
☐ Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on a case-by-case basis).

Health Care Provider Printed Name:_________________________Health Care Provider Phone No.: ___________________

I certify that_____________________________has the above contraindication and request their medical exception from influenza vaccination.

Health Care Provider Signature:__________________________________Date: ________________________
(Note: ink signature required – no digital or stamps)

Health Care Provider Medical License No.: ___________________________

Johns Hopkins affiliates please upload this document in the Johns Hopkins Vaccine Management System (VMS): vms.jh.edu
Please follow the links below to reach the most appropriate contact for questions.

Personnel Questions: Contact Us